211 CMR 51.00: PREFERRED PROVIDER ARRANGEMENTS (PPAs) AND PREFERRED PROVIDER PLANS

Section

51.01: Authority

211 CMR 51.00 is promulgated in accordance with the authority granted to the Commissioner of Insurance by M.G.L. c. 176I, § 8(a) and M.G.L. c. 176O, §17.

51.02: Applicability

No organization may offer a preferred provider plan until it is approved by the Commissioner in accordance with the provisions of M.G.L. c. 176I and 211 CMR 51.00. 211 CMR 51.00 shall not apply to organizations that furnish workers' compensation medical services through a preferred provider arrangement.

51.03: Definitions

As used in 211 CMR 51.00, the following words mean:

Benefit Level, health benefits provided to the covered person, as opposed to the payments made to the provider, by the health benefit plan.

Commissioner, the Commissioner of Insurance, appointed pursuant to M.G.L. c. 26, § 6, or his or her designee.

Covered Person, any policyholder, subscriber, member or dependent on whose behalf the insurer is obligated to pay for and/or provide health care services.

Covered Services, health care services which the insurer is obligated to pay for or provide under the health benefit plan.

Emergency Care, services provided in or by a hospital emergency facility to a covered person after the development of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average

knowledge of health and medicine, to result in placing the covered person's or another person's health in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

Emergency Medical Condition, a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the covered person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

Evidence of Coverage, any certificate, contract, or agreement issued to a covered person, including any amendments, riders, or supplementary inserts, stating the health services and benefits to which the covered person is entitled under the preferred provider plan.

Finding of Neglect, a determination by the Commissioner that an organization offering a preferred provider plan has failed to make and file the materials required by M.G.L. c. 176O or 211 CMR 52.00 in the form and within the time required.

Health Benefit Plan, the health insurance policy, subscriber agreement, plan, certificate, agreement, or contract between the covered person or health care purchaser and an organization which defines the covered services and benefit levels available.

Health Care Provider, a provider of health care services licensed or registered pursuant to M.G.L. c. 111 or c. 112.

Health Care Purchaser, a person, partnership, association, or corporation that provides health care coverage to its employees or members and their dependents by reimbursing the covered persons directly for covered health care services or by contracting with an organization to provide, arrange for the provision of, reimburse and/or pay for covered health care services.

Health Care Services, services rendered or products sold by a health care provider within the scope of the provider's license. The term includes, but is not limited to, hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

Insured Health Benefit Plan, a health benefit plan in which the organization assumes financial risk arising out of the contractual liability to pay for or reimburse covered persons for covered services. The term does not include a health benefit plan in which an organization functions solely as a third-party administrator.

Organization, an entity authorized by the Commissioner to bear risk, including, but not limited to companies licensed or otherwise authorized to write accident and health insurance pursuant to M.G.L. c. 175, fraternal benefit societies licensed or otherwise authorized to write accident and health insurance pursuant to M.G.L c. 176, non-profit hospital service corporations organized under M.G.L. c. 176A, medical service corporations organized under M.G.L. c. 176B, dental service corporations organized under M.G.L. c. 176E, optometric service corporations organized under M.G.L. c. 176F, or health maintenance organizations licensed pursuant to M.G.L. c. 176G.

Preferred Provider, a health care provider, group of health care providers or a network of providers who have contracted with an organization to provide specified covered services in the context of a preferred provider arrangement.

Preferred Provider Arrangement ("PPA"), a contract between or on behalf of an organization and a preferred provider that complies with the requirements of M.G.L. c. 176I and 211 CMR 51.00.

Preferred Provider Plan, an insured health benefit plan offered by an organization that provides incentives for covered persons to receive health care services from preferred providers in the context of a preferred provider arrangement.

51.04: Approval of Preferred Provider Plans

(1) Application. Any organization seeking approval of a preferred provider plan must submit an application in a format specified by the Commissioner that includes at least the following:

(a) A narrative description of the preferred provider plan to be offered;

(b) A description of the geographical area in which the preferred provider plan is to be offered, including a map of the area with the locations of all preferred providers;

(c) A description of the manner in which covered health care services and other benefits may be obtained by persons using the preferred provider plan, including any requirement that covered persons select a gatekeeper provider;

(d) Provider contracts and contracting criteria;

1. A narrative description of the financial arrangements between the organization and contracting health care providers, identifying any assumption by the providers of financial risk through arrangements such as per diems, diagnosis-related groups, capitation or percentage withholding of fees;

2. A copy of every standard form contract with physicians and other health care providers that will be part of the preferred provider plan, including providers included in the plan via leasing, subcontracting, or other arrangements whereby the organization does not contract directly with the providers (do not include rates of payment to providers);

3. A copy of every standard form contract for all preferred provider arrangements including administrative service agreements;

4. A copy of the terms and conditions that must be met or agreed to by health care providers desiring to enter into the preferred provider arrangement(s) that will be part of the preferred provider plan (do not include rates of payments to health care providers); and

5. A description of the criteria and method used to select preferred providers.

(e) A detailed description of the utilization review program;

(f) A detailed description of the quality assurance program;

(g) Benefits and services.

1. A copy of every standard form evidence of coverage for every preferred provider plan;

2. A description of any provision for covered services to be payable at the preferred level until an adequate network has been established for a particular service or provider type;

3. A description of all mandated benefits and provider types available at the preferred and non-preferred level;

4. A description of the incentives for covered persons to use the services of preferred providers;

5. A description of any provisions that allow covered persons to obtain covered health care services from a non-preferred provider at the benefit level for the same covered health care service rendered by a preferred provider;

6. A description of the grievance system available to covered persons, including procedures for the registration and resolution of grievances;

7. A copy of every standard form contract between the organization and health care purchasers for the preferred provider plan; and

8. A description of any provisions within the preferred provider plan for holding covered persons financially harmless for payment denials by, or on behalf of, the organization for improper utilization of covered health care services caused by preferred providers.

(h) Preferred Provider directory.

1. A copy of the preferred provider directory distributed to covered persons; and

2. A description of the process for distributing the directory to covered persons.

(i) Financial resources.

1. A description of the arrangements to be used by the organization to protect covered members from financial liability in the event of financial impairment or insolvency of any preferred provider that assumes financial risk; and

2. Evidence of a surety bond, reinsurance, or other financial resources adequate to guarantee that the organization's obligations to covered persons will be performed.

(j) Rates.

1. A description of the organization's methodology for establishing premium rates; and

2. A copy of the average rates for community-rated accounts, non-credible accounts, or their equivalent in the rating structure used by the organization.

(k) Evidence of compliance with M.G.L. c. 176O and 211 CMR 52.00.

(2) Review of Application. Upon receipt of a complete application, the Commissioner will review the submitted material to determine whether all requirements set forth in M.G.L. c. 176I and 211 CMR 51.00 have been met, including the following:

(a) Corporate and organizational structure capable of supporting the benefits offered;

(b) Contractual agreements that adequately protect the interests of members;

(c) Utilization systems ensuring the appropriate and efficient use of health services;

(d) Quality assurance system monitoring the quality of care provided to members;

(e) Clear and logical plan for marketing of the preferred provider plan;

(f) Adequate preferred provider networks to guarantee that all services contracted for will be accessible to members on a preferred basis and in all cases without delays detrimental to the health of members;

(g) Operations capable to administer the preferred provider plan and to maintain financial and utilization data for the preferred provider plan in a form separate or separable from other activities of the organization; and

(h) Sufficient financial reserves to support introduction of a preferred provider plan.

(3) Approval of Application. Each preferred provider plan, approved under M.G.L. c. 176I and 211 CMR 51.00, may continue to be marketed unless such approval is subsequently revoked by the Commissioner.

(4) Denial Of Application. If an application is denied or a plan is subsequently disapproved, the Commissioner shall notify the organization in writing, stating the reason(s) for the denial. The organization shall have the right to a hearing within 45 days of its receipt of such notice by filing a written request for hearing within 15 days of its receipt of such notice. Within 30 days after the conclusion of the hearing, the Commissioner shall either grant approval or shall notify the applicant in writing of the denial, stating the reason(s) for the denial. The organization shall have the right to judicial review of the Commissioner's decision in accordance with the provisions of M.G.L. c. 30A, § 14.

51.05: Evidence of Coverage

The evidence of coverage, including all amendments and material changes, must be submitted to the Commissioner for approval.

(1) The evidence of coverage must meet the requirements of M.G.L. c. 176I, M.G.L. c. 176O , 211 CMR 51.00, 211 CMR 52.00.

(2) The evidence of coverage must also include the following in clear and understandable language:

(a) a complete description of the benefit differential between services offered by preferred and non-preferred providers;
(b) Provisions that if a covered person receives emergency care and cannot reasonably reach a preferred provider, payment for such care will be made at the same level and in the same manner as if the covered person had been treated by a preferred provider;
(c) Benefit levels for covered health care services rendered by non-preferred providers must be at least 80% of the benefit levels for the same covered health care services rendered by preferred providers. Payments made to non-preferred providers shall be a percentage of the provider's fee, up to a usual and customary charge, and not a percentage of the amount paid to preferred providers. The 80% requirement shall be met if the coinsurance percentage for a covered health care service rendered by a non-preferred provider is no more than 20 percentage points greater than the highest coinsurance percentage for the same covered health care services rendered by a preferred provider, excluding reasonable deductibles and copayments; and
(d) A description of all benefits required to be provided by law in accordance with all of the provisions of the organization's enabling or licensing statutes.

51.06: Reporting

(1) Material Changes. Each organization offering a preferred provider plan shall file with the Commissioner any material changes or additions to the material previously submitted on or before their effective date, including amendments to the evidence of coverage and significant changes to the lists of preferred providers.

(2) Annual Reports. Each organization offering a preferred provider plan shall annually file with the Commissioner, within 120 days of the close of its fiscal year, a report covering its prior fiscal year. The annual report shall include at least the following information in a format specified by the Commissioner:

(a) A summary of the number of covered persons in preferred provider plans;
(b) A summary of the utilization experience of persons covered by preferred provider plans; and
(c) A current provider directory which lists preferred providers by specialty and geographic area.

(3) The Commissioner may require an organization to submit additional reports other than those specifically required by M.G.L. c. 176I.

(4) Penalties.

(a) The Commissioner may, after due hearing, require any person or organization found to have violated any provision of M.G.L. c. 176I or 211 CMR 51.00, or any rule or order thereunder, to forfeit an amount not to exceed $10,000 for any single violation.
(b) If the Commissioner issues a finding of neglect on the part of an organization offering a preferred provider plan, the Commissioner shall notify the organization

in writing that the organization has failed to make and file the materials required by M.G.L. c. 176O or 211 CMR 52.00 in the form and within the time required. The notice shall identify all deficiencies and the manner in which the neglect must be remedied. Following the written notice, the Commissioner shall fine the organization $5000 for each day during which the neglect continues.

(c) Following notice and hearing, the Commissioner shall suspend the organization's authority to do new business until all required reports or materials are received in a form satisfactory to the Commissioner and the Commissioner has determined that the finding of neglect can be removed.

51.07: Severability

If any provision of 211 CMR 51.00 or the applicability thereof to any person, entity or circumstance is held invalid by a court, the remainder of 211 CMR 51.00 or the applicability of such provision to other persons, entities or circumstances shall not be affected thereby.

REGULATORY AUTHORITY

211 CMR 51.00: M.G.L. c. 176I, § 8(a) and M.G.L. c. 176O, §17.

g:\health\c141\211cmr51\51wrev.doc